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ABSTRACT

There has been increased interest in family systems approaches to the treatment of children's behavior problems. A study was conducted to compare children's behavior patterns in clinical and nonclinical intact families and to explore the relationship between family functioning and boys' behavior patterns. Subjects consisted of 16 clinic families who were clients of a child guidance center, and 14 non-clinic families recruited from the community. All families consisted of at least one male child between the ages of 6 and 12, and his biological parents. Families were assessed using self-reports of family process and boys' behavioral functioning. The results showed significant differences between groups on behavioral functioning and family process variables. Boys in nonclinical families were reported to have significantly fewer and less severe behavior problems than boys in clinical families. The measure of family process indicated that clinical families reported significantly poorer problem solving and communication skills than nonclinical families. In addition, clinical families rated themselves as more disengaged and less adaptable than did nonclinical families. There was also a significant relationship between children's behavior problems and family processes such that more behavior problems correlated with more dysfunctional family processes. (Author/NRB)

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A COMPARISON OF CHILDREN'S BEHAVIOR PROBLEMS IN CLINICAL AND NONCLINICAL INTACT FAMILIES[1]

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A COMPARISON OF CHILDREN'S BEHAVIOR PROBLEMS IN CLINICAL AND NON-CLINICAL INTACT FAMILIES

ABSTRACT

This study compared children's behavior patterns in clinical and nonclinical intact families. The relationship between family functioning and boy's behavior patterns was also explored. Thirty families (N = 15 per group) were assessed using self-reports of family process and boy's behavioral functioning. Significant differences between groups were found on behavioral functioning and family process variables. Boys in nonclinical families were reported to have significantly fewer and less severe behavior problems than boys in clinical families. The measures of family process indicated that clinical families reported significantly poorer problem solving and communication skills than nonclinical families. In addition, clinical families rated themselves as more disengaged and less adaptable than nonclinical families. There was also a significant relationship between children's behavior problems and family processes such that more behavior problems correlated with more dysfunctional family process. Implication for treatment and future research are discussed.

A Comparison of Children's Behavior in Clinical and Nonclinical Intact Families

The increased interest in family systems approaches to the treatment of children's behavior problems has necessitated the development of valid measures of family process and organization. Much of the early work in the field focused on direct observations of family interactions that might distinguish clinical and nonclinical families (Jacob, 1975). This line of research has produced some useful findings concerning important differences in clinical and nonclinical family interaction patterns. More recent research has focused on developing valid self-report measures of family process and organization (Bray, Williamson & Malone, 1984; Epstein, Baldwin & Bishop, 1983).

The purpose of this study was to investigate the ability of two family process questionnaires to distinguish clinical and nonclinical families. Also, the relationship between family process variables and boy's behavior problems was studied.

METHODS

Subjects:

The subjects for this study consisted of 16 clinic families and 14 non-clinic families. In all cases families consisted of at least one male child (6-12 years old) and his biological parents. Clinic families were selected from the rosters of Houston Child Guidance Center (HCGC). Nonclinic families were obtained with the aid of community advertising and local churches. In addition to criteria listed above, nonclinic families had no member in treatment for psychological problems for at least two years and the identified target child was not considered a school problem by the parents. The parents and target child participated in the research.

Instruments:

1. Family Adaptability and Cohesion Evaluation Scales II (FACES II; Olson, Portner & Bell, 1982)
2. McMaster Family Assessment Device (FAD; Epstein, Baldwin & Bishop, 1983)
3. Conners Parent Questionnaire (CPQ; Conners, 1970)

Procedures:

If a clinic family agreed to participate, an appointment was made at HCGC for an initial interview. The adults in families were sent an agency application form, the CPQ, FACES, FAD and an informed consent form by mail to complete before the first interview. Subjects were instructed to complete their questionnaires separately and not discuss their answers with other family members. The same procedures were used with nonclinic families, except they were not mailed an agency application form.

When a family arrived at HCGC their questionnaires were collected and they were given additional information about the study. Families then partici- pated in a structured interview. The interviews were videotaped. Following data collection, the families were debriefed about the study and given feedback. Clinic families then participated in regular treatment activities at HCGC.

Data Analysis:

The design of this study is a one-way multimeasure-multimethod design. To study differences in family process and organization multivariate analysis of variance (MANOVA) was employed.

RESULTS

Analysis of the FACES II, FAD, and CPQ for the mother and father scores revealed significant differences between the groups. Significant differences were found on the mother's FACES II scores, Multivariate $F(4,25) = 4.12$, $p < .011$. On mother's FACES II a significant difference was found between the Cohesion and Adaptability scores for the two groups. Non-clinic mothers tended to rate their families in the flexibly connected category, whereas clinic mothers tended to rate their families in the structurally disengage[d] category. On father's FACES II a significant difference was found between groups for Adaptability scores. The same pattern as described for mothers' scores emerged. See Table 1 for means, standard deviations and univariate F-tests.

For FAD ratings, clinic mother scores were significantly different from non-clinic mother scores across all FAD scales. See Table 2 for means, standard deviations and univariate F-tests. There were significant differences on three of the father's FAD scales. Clinic families rated

themselves lower on communication skills, less affective involvement, less success at problem solving, and less affective responsiveness then their non-clinic counterparts.

For the CPQ a significant difference was found between the two groups for mothers' overall ratings. See Table 1. Clinic families reported significantly more problems with their children than nonclinic families.

Table 3 presents the correlations between the measures of family process and organization and ratings of boy's behavior problems. Most of the family measures correlate significantly with the ratings of boy's behavior for both mothers and fathers. The negative correlations between the FACES II scores and the CPQ indicate that higher levels of cohesion are associated with fewer behavior problems. Higher levels of adaptability correlate with fewer behavior problems in children. The positive correlations between the FAD scales and the CPQ indicates that more behavior problems are associated with more pathological family ratings.

DISCUSSION

The results of this study indicate that there are significant differences between clinical and nonclinical families in terms of family process and organization. Nonclincal families reported fewer problems with their sons and reported more balanced family functioning, and more effective communication and problem solving skills than clinic families. The results also support the validity of both the FACES II and the FAD as indicators of family process. As theorized by Olson et al. (1982) nonclinic family scores fell within the balanced range, whereas the clinic family scores fell in the midrange to extreme area. The results are also consistent with the general family therapy literature (Gurman & Kniskern, 1981) which suggests that difficulties with communication, problem solving and unclear roles in families are associated with a higher incidence of problems in children.

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Table 1
Means, Standard Deviations and F-Tests
for Clinical and NonClinical Families

Variable	Clinical	NonClinical	F-Test	P<
Mothers FACES				
Cohesion	56.44	67.86	14.77	.01
	10.40	4.13		
Adaptability	44.25	51.43	7.47	.01
	8.65	4.96		
Father's FACES				
Cohesion	59.73	64.78	3.65	.07
	8.73	4.80		
Adaptability	46.07	50.50	4.08	.05
	5.79	6.02		
Mother's CPQ	178.94	141.14	14.88	.01
	28.04	25.32		

Table 2
Means, Standard Deviations and F-Tests
for Family Assessment Device Scales

Variable	Clinical	Non-Clincial	F-Tes'	P<
Mother's				
Gen. Func.	26.25 (6.31)	18.79 (4.63)	13.31	.01
Prob. Sol.	11.37 (2.60)	9.29 (2.27)	5.41	.03
Comm.	13.94 (3.02)	10.64 (1.98)	12.06	.01
Roles	22.19 (3.53)	17.00 (3.72)	15.35	.01
Aff. Inv.	17.00 (4.30)	12.79 (2.89)	9.61	.01
Aff. Resp.	13.25 (2.72)	10.29 (3.17)	7.59	.01
Behav. Cont.	17.50 (3.63)	14.50 (2.59)	6.59	.02
Father's				
Gen. Func.	24.50 (6.64)	19.64 (5.98)	4.38	.05
Prob. Sol.	10.37 (2.78)	8.86 (2.54)	2.41	.13
Comm.	13.06 (2.77)	11.64 (3.08)	1.77	.19
Roles	19.31 (4.33)	17.29 (2.81)	2.23	.15
Aff. Inv.	16.06 (3.21)	12.64 (3.03)	8.92	.01
Aff. Resp.	13.31 (3.00)	10.64 (3.77)	4.65	.04
Behav. Cont.	16.69 (3.32)	14.79 (2.24)	3.29	.08

df = 1, 28

Table 3
Correlations Between CPQ, FACES II and FAD

Variable	Mother's CPQ
Mother's FACES	
Cohesion	-.63*
Adaptability	-.39*
Mother's FAD	
General Functioning	.56*
Communication	.59*
Roles	.66*
Affective Involvement	.47*
Behavior Control	.37*
Affective Response	.49*
Problem Solving	.46*
Father's FACES	
Cohesion	-.50*
Adaptability	-.41*
Father's FAD	
General Functioning	.51*
Communication	.34*
Roles	.38*
Affective Involvement	.51*
Behavior Control	.24
Affective Response	.35*
Problem Solving	.34*

*$p < .05$